State of Idaho, Division of Medicaid
Aldara® (Imiquimod) PRIOR AUTHORIZATION FORM
CONFIDENTIAL INFORMATION

Phone: 1-208-364-1829 *One drug per form ONLY – Use black or blue ink* **Fax: 1-208-364-1864**

Patient Name: _____	Medicaid ID#: _____	Date of Birth: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#:	Phone:	Fax:

Aldara® is approved for payment for eligible participants that have a diagnosis of venereal warts or actinic keratosis. Approval is for a maximum of 16 weeks.

- ❑ Aldara Cream 5% topically at bedtime three times per week
- ❑ Aldara Cream 5% topically two times per week

Diagnosis

- ❑ Venereal warts (ICD-9 = 0.78.11)
- ❑ Actinic Keratosis (ICD-9 = 702.0)
- ❑ Other _____

To ensure continuity of care, please make sure corresponding ICD-9 diagnosis codes are submitted on professional office claims to Medicaid on a routine basis.

Is this the participant's first prior authorization request for Aldara?

- ❑ Yes
- ❑ No

Additional information which may aid in the Prior Authorization decision making process:

_____

_____

_____

Prescriber Signature:_____ **Date**:_____

By signing, prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date:	RPh:	Tech:	PA#:
Approved	Denied	Comments:	

All current PA forms and criteria for use are available at: http://www.medicaidpharmacy.idaho.gov (PA Criteria & Forms)

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